

THE STATE OF NEW HAMPSHIRE



CHILD FATALITY REVIEW COMMITTEE

SECOND ANNUAL REPORT

Presented to:
The Honorable Jeanne Shaheen
Governor, State of New Hampshire
October, 1999

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Funding for this report and for the activities of the Child Fatality Review Committee comes from the U.S. Department of Health and Human Services Administration on Children, Youth and Families through the Children's Justice Act Grant (#G-9801NHCJA1) which is administered by the New Hampshire Department of Justice.

October 15, 1999

Dear Friends of New Hampshire Children:

As I complete my first full year as Chair of the Child Fatality Review Committee, I want to acknowledge the dedicated and insightful members of this Committee who, through their hard work and commitment, have made my job much easier.

The task of reviewing child deaths is a difficult one, yet we are sustained by the knowledge that this work is important and that we can make a difference in helping to prevent future child fatalities in New Hampshire.

Much of what the Committee has accomplished in the last few years has been the direct result of multidisciplinary coordination, communication and cooperation. Our mission calls upon us to continue building on the work we have started by fostering teamwork and enhancing information sharing. New Hampshire has a unique opportunity to strengthen its commitment to children through interagency collaborative efforts. We believe that we have made significant advances in this area and look forward to continual progress in the future.

It is with great pride that we present the Second Annual Report to the Honorable Jeanne Shaheen, Governor of the State of New Hampshire.

Sincerely,

Marc Clement, Ph.D.
Chair
New Hampshire Child Fatality Review Committee

DEDICATION

The Child Fatality Review Committee dedicates this report to the children of New Hampshire. What sustains us in this difficult work is the knowledge that what we do may help make the lives of New Hampshire's children safer, and prevent tragic and untimely deaths.

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

MISSION STATEMENT

To reduce preventable child fatalities through systematic multidisciplinary review of child fatalities in New Hampshire; through interdisciplinary training and community-based prevention education; and through data-driven recommendations for legislation and public policy.

OBJECTIVES

1. To describe trends and patterns of child death in New Hampshire.
2. To identify and investigate the prevalence of risks and potential risk factors in the population of deceased children.
3. To evaluate the service and system responses to children who are considered high risk, and to offer recommendations for improvement in those responses.
4. To characterize high-risk groups in terms that are compatible with the development of public policy.
5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of the cause of death on death certificates.
6. To enable parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

CHILD FATALITY REVIEW COMMITTEE MEMBERSHIP

Chair: Marc Clement, PhD
Colby-Sawyer College, CASA of NH

Jacqui Abikoff, ACSW, LADC
Horizon's Counseling Center

Thomas Andrew, MD
NH Chief Medical Examiner

Suzanne Bolduc, CCSW, LICSW
Child & Family Forensic Center
University of Massachusetts Medical Center

John Brooks, MD
Department of Pediatrics
Dartmouth-Hitchcock Medical Center

Katherine Descheneaux, Chief Forensic Investigator
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NH Department of Health & Human Services

Carol Frechette, RN
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Division for Children, Youth & Families
NH Department of Health & Human Services

Linda Griebisch, Public Policy Director
NH Coalition Against Domestic & Sexual Violence

Cynthia Hambrook
Task Force Program Specialist
NH Attorney General's Office

Honorable David Huot
Laconia District Court

Joyce Johnson, RN, MS
NH Department of Education

John Kissinger, JD
NH Attorney General's Office

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NH Department of Health & Human Services

Audrey Knight, MSN, ARNP
NH SIDS Program Coordinator
NH Department of Health & Human Services

Sandra Matheson, Director
Office of Victim/Witness Assistance
Attorney General's Office

Grace Mattern, Executive Director
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Nancy Mogielnicki, PAC, MPH
Community Health Center
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Family Services Unit
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Nancy Palmer, RN
Community Health Nurse

Joe Perry, Director
Division of Behavioral Health Services
NH Department of Health & Human Services

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Rosemary Shannon, MSW
Bureau of Substance Abuse Services
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NH Department of Health & Human Services

Marcia Sink, Executive Director
CASA of New Hampshire

Elizabeth Thompson, RN
Medicaid Administration Bureau
NH Department of Health & Human Services

I. HISTORY, BACKGROUND AND METHODOLOGY

In 1994, there were **181** deaths in the state of New Hampshire involving children up to the age of 18. This compared to 176 child fatalities in 1995 and 162 in 1996. The data presented here and in the Committee's First Annual Report show that the great majority of the child fatalities in New Hampshire are from natural causes and that relatively few children die of preventable injury. It is the task of the Child Fatality Review Committee to review child deaths and ascertain whether certain actions could have been taken to prevent these tragedies.

The Committee's First Annual Report provided an overview of the history of child fatality review committees from their founding in Los Angeles County in 1978. In 1991, then Governor Judd Gregg signed an Executive Order creating a multidisciplinary Child Fatality Review Committee here in New Hampshire. To assist with the initial implementation of the Committee, the University of New Hampshire Family Research Laboratory was commissioned to conduct a base-line study of child deaths in New Hampshire and to provide recommendations for how the Committee should operate.

After reviewing the study findings and initiatives from other states, the Committee was restructured to accommodate the demands of an on-going review process. In 1995, in an effort to support the restructuring, then Governor Stephen Merrill signed a new Executive Order (see Appendix A) re-establishing the Committee under the official auspices of the New Hampshire Department of Justice. The Executive Order authorizes the Committee to have access to all existing records regarding child deaths, including social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical data and other information that may be relevant to the review of a particular child death. To provide further support to the review process, the department heads of the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety signed an Interagency Agreement (see Appendix A) that defined the scope of information sharing and confidentiality within the Committee. Additionally, individual Committee members and invited participants are required to sign Confidentiality Agreements (see Appendix A) in order to participate in the review process.

The New Hampshire Child Fatality Review Committee is funded by the New Hampshire Department of Justice through the Children's Justice Act (CJA) Grant, which is administered by the US Department of Health and Human Services. In order to receive funding through the CJA Grant, which also supports the Attorney General's Task Force on Child Abuse and Neglect, the State is required by statute to establish a child fatality review panel "to evaluate the extent to which agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review panel (see Appendix B).

The Committee membership is comprised of representation from the medical, law enforcement, judicial, legal, victim services, public health, mental health, child protection and

education communities. Currently, the Committee has a dual structure consisting of the full Committee, which convenes bimonthly to conduct in-depth reviews of specific cases involving child fatalities, and a Sub-Committee, which convenes on alternate months to select cases for review, collect data and provide organizational support to the Committee.

The Committee began reviewing cases of child fatalities in January of 1996. In addition to the regular meeting schedule, the Committee hosted a joint meeting in November of 1998 with Child Fatality Review Teams from Vermont, Maine and Massachusetts. This meeting provided a forum for participants to come together and learn about some of issues that other teams encounter in their efforts to review child deaths. It also offered an opportunity for members to establish contacts with their counterparts in other states. Participants from the four states plan to meet annually to further explore areas of common interest and to examine in more detail how each state conducts case reviews.

In New Hampshire, cases to be reviewed by the full Committee can be selected by individual members or agencies. The Committee does not review cases that have criminal and/or civil matters pending. After a case is found to be appropriate for review, the Sub-Committee begins to gather information and invite participants from outside the committee who have had direct involvement with the child or family prior to the child's death.

Each child death is reviewed using the following review process (see Case Review Protocol, page three):

- The Medical Examiner's Office presents a clinical summary of the death. Other participants who had prior involvement with the child and family then present relevant medical, social and legal information.
- The Committee discusses service delivery prior to the death, and the investigation process post death.
- The Committee identifies risk factors related to the death and makes recommendations aimed at improving systematic responses in an effort to prevent similar deaths in the future.
- The Committee provides recommendations to participating agencies and encourages them to take actions consistent with their own mandates.

At the end of each year, the appropriate agencies are asked to respond to the recommendations generated from the prior year's reviews. These responses are published in the subsequent year's annual report. Responses to the recommendations published in The First Annual Report to the Governor begin on page nine of this report.

II. CASE REVIEW PROTOCOL

1. The Committee will review data regarding all deaths of New Hampshire children up to and including 18 years old.
2. Comprehensive, multidisciplinary review of any specific cases may be initiated by the Department of Justice, the Department of Health and Human Services, the Department of Safety, or by any member of the New Hampshire Child Fatality Review Committee (CFRC).
3. The review process begins with obtaining a list of in-state child deaths from the New Hampshire Department of Health and Human Services and/or from the Office of the Chief Medical Examiner.
 - A. The deaths are then sorted by manner of death: natural, homicide, traffic, suicide, accident other than traffic.
 - B. Prior to clinical review, relevant records (e.g.: autopsy reports, law enforcement, Division for Children Youth and Families) are obtained.
 - C. Cases may be selected for full Committee review by the Sub-Committee from a variety of resources and documents which enumerate children's deaths and their cases from 1994 on.
 - D. The review focuses on such issues as:
 - Was the death investigation adequate?
 - Was there access to adequate services?
 - What recommendations for systems changes can be made?
 - Was the death preventable?*
4. After review of all confidential material, the Committee may provide a summary report of specific findings to the Governor and other relevant agencies and individuals.
5. The CFRC will develop periodic reports on child fatalities, which are consistent with state and federal confidentiality requirements.
6. The CFRC will convene at times published.
7. Each CFRC member will have an alternate member from their discipline or agency and will ensure that one member will be present at every meeting.
8. Confidentiality Agreements are required of any individual participating in any CFRC meeting.
9. The CFRC Sub-Committee, comprised of members of the CFRC, assesses case information to be reviewed by the CFRC and performs other business as needed.

***WHAT IS A PREVENTABLE DEATH?**

A preventable death is one in which, by retrospective analysis, it is determined that a reasonable intervention (e.g., medical, educational, social, legal or psychological) might have prevented the death. "Reasonable" is defined as taking into consideration the conditions, circumstances, or resources available.

III. REVIEW AND ANALYSIS OF DATA

The Second Annual Report examines the data on child fatalities from 1995 and 1996. In 1995, there were 176 child fatalities in the State of New Hampshire. Of this total, 71% were from natural causes, 18% from unintentional injuries, 8% suicide, and 3% homicide. In 1996, there were 162 child fatalities. Of this total, 73% were from natural causes, 22% unintentional injuries, 3% suicide, and 3% homicide. Small numbers make it difficult to draw definitive conclusions from this data, but it should be noted that there was a significant increase in the number of suicides in 1995 compared with 1994 and 1996.

This report includes data from child fatalities for children ages birth through 19. This portion of the data coincides with the data compiled in the Vital Statistics Report published by the New Hampshire Department of Health and Human Services' Bureau of Vital Records and Health Statistics. To allow for comparisons with the data from the First Annual Report, data for children ages birth through 18 is included.

Findings and recommendations presented in the next section are based on thorough Committee reviews of selected child fatalities during 1995 and 1996.

NATURAL CAUSES: AGES 0 - 19

	Ages 0 - 1	Ages 1 - 19	Total
1995	77	48	125
1996	72	36	118

AGE DISTRIBUTION OF INJURY DEATHS BY GENDER: 0 - 19: 1995/1996

	1995			1996		
	Male	Female	Total	Male	Female	Total
Under Age 1	1 (2%)	1 (2%)	2 (4%)	1 (2%)	2 (4%)	3 (6%)
1 - 14	7 (13%)	7 (13%)	14 (26%)	13 (28%)	4 (9%)	17 (37%)
15 - 19	24 (45%)	13 (25%)	37 (70%)	18 (39%)	8 (17%)	26 (56%)
Total	32	21	53	32	14	46

INJURY DEATHS: 0 - 19 YEARS

	0 - 1	1 - 4	5 - 9	10 - 14	15 - 19	TOTAL
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1995						
Unintentional	1	1	4	7	19	32
Suffocation	1	1	1	0	0	3
MV Crash	0	0	0	1	15	16
MV Pedestrian	0	0	1	1	2	4
MV Bicycle	0	0	0	0	0	0
Other Transport	0	0	0	0	0	0
Drowning	0	0	1	2	1	4
Fire	0	0	1	1	0	2
Cut/Pierce	0	0	0	1	0	1
Firearm	0	0	0	0	1	1
Fall	0	0	0	0	0	0
Other	0	0	0	1	0	1
Homicide	1	1	1	0	2	5
Firearm	0	0	0	0	2	2
Cut/Pierce	0	0	0	0	0	0
Other	1	1	1	0	0	3
Suicide	0	0	0	0	14	14
Poisoning	0	0	0	0	1	1
Hanging	0	0	0	0	6	6
Firearm	0	0	0	0	7	7
1996						
Unintentional	2	5	4	6	18	35
Suffocation	2	1	0	0	0	3
MV Crash	0	1	2	2	17	22
MV Pedestrian	0	0	0	0	0	0
MV Bicycle	0	0	0	1	0	1
Other Transport	0	0	1	0	0	1
Drowning	0	3	1	2	0	6
Fire	0	0	0	0	0	0
Cut/Pierce	0	0	0	0	0	0
Firearm	0	0	0	0	0	0
Fall	0	0	0	1	1	2
Other	0	0	0	0	0	0
Homicide	1	0	1	1	1	4
Firearm	0	0	0	1	0	1
Cut/Pierce	0	0	1	0	1	2
Other	1	0	0	0	0	1
Suicide	0	0	0	0	5	5
Poisoning	0	0	0	0	1	1
Hanging	0	0	0	0	0	0
Firearm	0	0	0	0	4	4

INJURY DEATHS: AGES 15 - 18: 95/96

	1995	1996
Unintentional	15	13
MV Crash	13	12
Drowning	1	0
Fall	0	1
Firearm	1	0
Homicide	1	1
Firearm	1	0
Cut/Pierce	0	1
Suicide	11	4
Poisoning	1	1
Hanging	3	0
Firearm	7	3

CAUSES OF DEATHS FOR INFANTS: 1995/1996

	1995	1996
Certain Gastrointestinal	0	2
Pneumonia & Influenza	0	2
Congenital Anomalies	20	16
Certain Perinatal Conditions	27	35
Unintentional Injuries	2	2
Homicide	1	1
Ill-Defined Conditions (ex. SIDS)	16	9
Other Causes	11	5
Total	77	72

SUDDEN INFANT DEATH SYNDROME (SIDS): 1995/1996

Position at time of Discovery	1995	1996
On Stomach	5	3
On Side	3	3
On Back	5	2
Car Seat	1	0
Unknown	1	0
Total	15	8

IV. 1999 FINDINGS AND RECOMMENDATIONS

The Committee continued its in-depth review process throughout 1998 and covered a number of cases involving suicide, motor vehicle accidents, substance abuse and Sudden Infant Death Syndrome (SIDS). Although case reviews revealed many instances of high quality work, the need for increased multidisciplinary collaboration, policy revision and on-going professional training were recurrent themes throughout the year. Many of the Committee's findings identify opportunities for agencies to progress in these significant areas. Based upon the year's comprehensive case reviews, the Committee reports the following findings and recommendations, which are intended to help reduce child fatalities through enhanced policy development and service delivery within and among the agencies that serve children and families.

A. *PUBLIC HEALTH AND MEDICAL*

- Establish a flagging system to be used by emergency room physicians to assist in tracking cases where child abuse is suspected.
- Issue the death certificate only after all information has been reviewed.
- Identify the cause/manner of death to determine risk to other siblings, e.g., child abuse/neglect.
- Autopsy all deaths under 18 years.

B. *MENTAL HEALTH*

- Increase funding and resources for treatment and follow-up services for substance involved children, adolescents and teens.
- Increase mental health agencies' involvement in the Child Fatality Review process.

C. *EDUCATION SYSTEM*

- Review the Department of Education's protocol on reporting suspected child abuse and neglect.
- Develop driver's education guidelines that offer advice to parents on how to monitor and improve the driving skills of the student.

- Develop public education to inform parents of their ability to defer their teenager from driving if he/she is not mature enough.
- Develop guidelines that address the unique considerations of teens with special education issues who are preparing to become licensed drivers.
- Develop a protocol for information sharing which allows the public schools to provide private driver's education companies with a listing of all students who did not pass the driver's education course offered through the schools.

D. CHILD PROTECTIVE SERVICES

During the period of time covered by this year's report, only two (2) cases were reviewed that involved child protective services. The following recommendation was offered specific to the Division for Children, Youth and Families and is included in the Legislation section:

- Increase funding and resources to the Division for Children, Youth and Families in order to hire more front-line staff to decrease child protection workers' caseloads.

E. DISTRICT COURT AND LAW ENFORCEMENT

- Develop protocols that allow three months for Predisposition Investigation (PDI) to ensure thoroughness.
- Develop guidelines for judges and Juvenile Service Officers relative to making referrals to Bureau of Substance Abuse Services counselors for early identification and intervention in cases where substance use/abuse is suspected
- Develop guidelines for case review by judges and Juvenile Services Officers (JSO) to assess whether the treatment program is meeting the child's/adolescent's needs.

F. LEGISLATION

- Review existing legislation from other states and consider whether or not drafting legislation for New Hampshire could assist the Child Fatality Review Committee in its work.
- Change RSA 169-C: 35 to increase the time that child protection records are held.

- Increase funding and resources to the Division for Children, Youth and Families in order to hire more front-line staff to decrease child protection workers' caseloads.

V. RESPONSES TO 1998 RECOMMENDATIONS

The First Annual Report to the Governor, published in the Fall of 1998, gave a listing of recommendations which were generated from specific case reviews. Agencies and disciplines that were focused upon in this report were given an opportunity to respond to the recommendations. The following is a summary of the responses provided. For a complete list of the 1998 recommendations, please review the above referenced report.

A. PUBLIC HEALTH AND MEDICAL

The recommendations for these disciplines focused on training professionals in a number of areas including identification of abuse, organ donations, Shaken Baby Syndrome (SBS), and Sudden Infant Death Syndrome (SIDS).

While more remains to be done, training opportunities for pediatric health care practitioners continue to expand. The Attorney General's Task Force on Child Abuse and Neglect sponsors an Annual Conference on Child Abuse as well as a daylong training series which offer training on a wide range of child maltreatment topics which are geared toward multidisciplinary audiences, including health care providers. Recently, New Hampshire hosted the 1998 regional meeting of New England Radiological Technologists in Nashua, where there was a three-hour workshop on child abuse aimed specifically at this audience. In addition to some smaller scale, locally based presentations occurring across the state, the Child Abuse Referral Examination (CARE) Network has started conducting training on medical findings in children who have been sexually abused. This training program, which is targeted at emergency department physicians and nurses, uses the recently released educational slides developed by the American Academy of Pediatrics. To build upon the ongoing training efforts and to help standardize the medical examinations of children suspected of being abused, the Second Edition of the *Attorney General's Task Force on Child Abuse and Neglect - Protocol for the Health Care Practitioner* was published this year.

Organ and tissue donation continues to be a successful endeavor in New Hampshire. From 1996 to 1997, the number of donors referred to the New England Organ Bank (NEOB) and/or New England Eye and Tissue Transplant Bank (NEETTB) by the Office of the Chief Medical Examiner increased 50% from 12 to 18, and as of September 1998, 24 donors had been referred for that calendar year. Recent changes, as of August 1998, in the Health Care Finance Administration (HCFA) regulations require hospitals to report all deaths to their designated organ procurement organization for evaluation, requiring an extensive education

effort to hospitals around the state. In-service staff education and/or continuing medical education sessions were conducted by NEOB or NEETTB in 1998 at St. Joseph's Hospital, Valley Regional Medical Center, Concord Hospital, Wentworth-Douglass Hospital, Androscoggin Hospital, Exeter Hospital, Cottage Hospital, Southern New Hampshire Medical Center, Franklin Regional Hospital, Speare Memorial Hospital, Lakes Region Hospital, Huggins Hospital, Monadnock Hospital, Parkland Medical Center and New London Hospital. Similar sessions are scheduled at Catholic Medical Center and Elliot Hospital.

The New Hampshire Department of Health and Human Services Bureau of Emergency Medical Services (BEMS) partnered with the Emergency Medical Services for Children (EMS-C) Program at Dartmouth Medical School, the Bureau of Maternal and Child Health, the Office of Emergency Communications (E-911), and the Office of the Chief Medical Examiner to develop a medical protocol for unresponsive children for adoption by the Emergency Medical Services Medical Control Board and inclusion in the New Hampshire Local Option Patient Care Protocol, the statewide guidelines used by Emergency Medical Services (EMS) personnel. A training curriculum for SIDS was concurrently developed and presented by Thomas Andrew, M.D., the State's Chief Medical Examiner and Audrey Knight of the New Hampshire SIDS Program to all New Hampshire EMS Instructor/Coordinators for use in the initial and refresher EMS training programs. Within two years, every currently licensed EMS provider will receive this training as well as all new trainees.

In an effort to provide updated information on SIDS to the law enforcement community, the Committee will review the SIDS and Child Abuse component of the Police Standards and Training (PST) curriculum to see if additional information is needed. The Committee will forward any specific training recommendations to PST.

A revised and updated copy of Recommended Protocols for Suspected Cases of Sudden Infant Death Syndrome (SIDS), was mailed in October, 1998, to 69 New Hampshire deputy medical examiners; 608 pediatricians and family practice physicians; 97 Pediatric and Family Practice Advanced Registered Nurse Practitioners; and to 27 New Hampshire hospital Emergency Department Directors and 27 Social Service Department Directors. These Directors also received a survey evaluating the use of the protocols. A summary of the survey results is as follows: 26 of 27 hospitals responded after the initial mailing and a follow-up reminder letter. Of the 26, 65% (17) were familiar with the protocols; 19% (5) had used the protocols in some way since the original protocols had been sent out two years ago; 46% (12) were unsure if they had used the protocols; and 77% (20) planned to use the newly received, updated protocols in some way; 23% (6) were unsure of plans to use them. This survey indicated that hospitals now have the information and the majority plan to incorporate them into new or existing protocols or information packets to improve services to bereaved families.

B. MENTAL HEALTH

The Division of Behavioral Health (DBH), in response to the Committee's recommendations to enhance and increase training for community mental health center staff is pursuing the following actions:

- DCYF will be scheduled to provide training to all Children's Directors of the ten community mental health centers on neglect/abuse reporting and investigation procedures.
- DCYF will be scheduled to provide training to the Philbrook Center and Adolescent Unit staff of New Hampshire Hospital on neglect and abuse reporting and its relation to inpatient evaluation and treatment.
- DBH will review the staff orientation and training programs for both the Adult and Children's Programs of community mental health centers relating to work with high risk parents, abuse/neglect reporting and DCYF procedures.
- DBH has made training on the wraparound process a part of its strategic training plan. One regional training has occurred this year.

C. EDUCATION SYSTEM

Recommendations specific to the education system included concerns with driver's education and training for school personnel regarding protocols for reporting suspected child maltreatment. The New Hampshire State Department of Education (SDE) continues to administer the Youth Risk Behavior Survey (YRBS) every two years. Findings are extensively shared with school districts and other interested groups and the results are used to develop and strengthen policies and school-based programs.

Findings regarding child fatality trends and patterns were shared with the members of the SDE's Safe School Committee as well as school administrators. A comprehensive tool to assess the safety of schools was adapted by this group and distributed to school administrators in the spring of 1999. In addition, the Safe School Committee now has a web site linked to the SDE that will provide a variety of resources for districts.

School nurses who are on the New Hampshire School Nurse List Serve were offered Child Abuse Prevention Packets to help plan various prevention activities. Approximately 40 nurses requested these packets. In addition, school nurses attending conferences over the winter of 1999 were also offered these packets

With regard to driver's education, SDE's role has not been to directly provide education to parents but rather to share information with local programs so that they can conduct parent nights to solicit parent participation in teaching their children. The passage of House Bill 491 during this legislative session, requiring 20 hours of documented parent practice with a new driver, should support some greater parent involvement.

SDE supports the provision of quality driver education programs for beginning drivers in both the secondary and commercial motor vehicle driving schools through teacher certification activities; support of various professional development programs; development and provision of resources to support course content and delivery; and by providing technical assistance to local programs. SDE works with Keene State College to insure delivery of an appropriate, comprehensive teacher preparation program. Driver education teachers all must meet the same standards for recertification as are required of teachers in any other instructional or administrative area. Annual conferences and workshops are sponsored by the SDE or jointly sponsored with other organizations such as the New Hampshire Driver Education Teachers Association or the New England Traffic Safety Education Association. SDE provides information on new instructional materials and technology changes to enhance local programs. It also serves as a lending resource center for some audiovisual and instructional materials. The agency has promoted programs such as the Sharing the Highway large vehicle awareness program with the New Hampshire Motor Transport Association and the Safety Belt Challenge with the New Hampshire Highway Safety Agency.

D. CHILD PROTECTION SERVICES

The recommendations in this area focused on concerns with the Central Registry, intake and assessment procedures, community and staff training and overall policy development. In response to these recommendations, the Division for Children, Youth and Families (DCYF) provided the following information.

Currently, the Central Registry maintains the names of people who abuse/neglect children for 7 years in founded cases and for 3 years for unfounded reports. The work of DCYF is based on the premise that people can and do change, and when DCYF becomes involved, they work with the family toward that goal. The Division believes that their work can, and does make significant changes in the manner in which family members interact with one another. The Central Registry is used by the Department to assist in identifying those people who pose a significant risk to children, primarily in their families. For those situations outside the family and where there has been a significant risk, the police arrest and charge persons for crimes against children and also maintain a record of those events. The Eric L. settlement agreement has also mandated that the agency account for the impact that previous referrals may have had on current circumstances, and this phase of the assessment process will play an important role in work on the current referral.

The DCYF Intake Guidelines determine how reports are taken by staff, and provide for ample opportunity for discussion with the reporter about their concerns. There are times when the reporters are unclear about the role of the DCYF and are reporting concerns which do not rise to the level or type of concern necessary to warrant DCYF's involvement. In this instance, referrals to other agencies may be more appropriate.

There are currently a number of initiatives underway at DCYF which include a thorough review of all current policies and procedure with the goal of improving all of the procedures to a “best practices” standard. One desired outcome of this process is to reduce the number of repeat referrals on any family/child. Although not policy at this time, the practice in many of the District Offices regarding multiple referrals has been to assign a different assessment worker after there have been three unfounded outcomes.

At present, DCYF’s Assessment policy requires that the parents/caretakers and all children residing in the home, whether or not they are identified as possible victims, must be interviewed by the DCYF Assessment Child Protection Service Worker (CPSW). Supervisory approval must be documented for any exception to seeing all children in the household. Further, policy also states that face-to-face contact with the family is required within 72 hours of assignment to the CPSW to assess the risk to the child. Assessment CPSWs are required to “use best efforts” (by either telephone or letter) to make contact with all professional reporters both at the beginning stages of the assessment, and again before making a final determination that the report is unfounded. A professional reporter who disagrees with an unfounded determination is to be referred to the Supervisor.

Training for community professionals and others regarding the Child Protection Act, the obligation to report and the reporting process has been a recurrent concern in many child fatality case reviews. The DCYF Staff Development Unit has recently implemented a Speaker’s Bureau to effectively respond to requests for presentations throughout the state on all program areas for which DCYF is responsible, including child protection. In addition, DCYF staff regularly participate in a multitude of pre-service and in-service training programs for professionals specific to the child abuse and neglect reporting process. Some examples are the Preventing Abuse and Neglect through Dental Awareness (PANDA) program, a partnership with Delta Dental, New Hampshire Dental Society, and Prevent Child Abuse New Hampshire, and the Sexual Assault Nurse Examiner’s certification program. Additionally, thousands of copies of the Division’s publication, “A Community Guide to Reporting Child Abuse and Neglect” have been distributed since it’s development in Fall, 1996. The idea of a developing a standard reporting form is currently under review.

Additional training initiatives target the problem of drug and alcohol use/misuse and the effects upon children and their families. DCYF recently received grant funding under Title IV-E, to enable them to work with specialized staff and other resources to improve the Division’s knowledge base regarding this issue. This demonstration project, which includes a strong research component, is just getting started in two sites, with the expectation that this work will expand to include all of the District Offices, and increase our partnerships with local community agencies and providers.

DCYF is committed to best practice standards, and is currently undergoing a comprehensive review of all existing policies and practices with the overall goal of achieving national accreditation certification over the next several years, with a view to instilling “best practice” standards in all DCYF activities.

E. DISTRICT COURT AND LAW ENFORCEMENT

Recommendations in these areas were relative to the need for victim services in domestic violence cases within the District Courts and to standardizing reporting requirements.

The AmeriCorps Victim Assistance Program (AVAP) provides services during the civil process in most of the District Courts as well as services during the criminal process in the major District Courts. The program has been assured continued funding through the next year. In addition, the State has used the Violence Against Women Act federal grant to fund victim/witness advocates in the Manchester, Portsmouth and Rochester District Courts and in Districts Courts in Merrimack County and Rockingham County through the county attorney offices.

The 1999 legislative session passed House Bill 652 that doubled the funding for the New Hampshire Victim Assistance Fund with some money to go into expanding district court victim services. The bill also added a 5% surcharge on all goods purchased at the commissaries of the State prisons to be designated solely for the district court programs.

The courts are also displaying brochures produced by the New Hampshire Coalition Against Domestic and Sexual Violence on stalking, domestic violence and the elderly, and domestic violence and teens.

Currently, there are no formal protocols in place within the Superior, District or Family Courts that address issues relating to children in the home when restraining orders are heard, or that provide guidelines for reporting the presence of children to DCYF. Court practice on these issues is inconsistent some courts ask and report, others do not. If a committee is reconvened to revise the District Court section of the Attorney General's Task Force on Child Abuse and Neglect Protocol or the Domestic Violence Protocol, these issues may be addressed.

The issue concerning inquiries about firearms has been addressed through the passage of Legislative House Bill 722, which mandates relinquishment of firearms with a permanent domestic violence order. Also, it requires that court clerks inform victims that relinquishment of firearms can be requested in a temporary order. In response to the recent legislation, courts will be receiving updated directives informing them about these new provisions. Victim advocates are trained to ask about lethality (substance abuse, firearms, threats, etc.) and try to make that information available to police. However, because of confidentiality, police and courts are only informed if the victim consents.

VI. CONCLUSION

The Committee hopes that this report will inform the public of the on-going efforts to reduce preventable child deaths in New Hampshire and challenge the professional community

and the legislature to act now in evaluating the policies, procedures, services and laws that impact their work with children and families.

In the coming year, we will continue to critically review cases and offer recommendations designed to enhance public policy and strengthen prevention and intervention efforts as we work toward our goal of reducing preventable child deaths and helping children in New Hampshire to lead safe and healthy lives.

VII. APPENDICES

APPENDIX A. CHILD FATALITY REVIEW COMMITTEE OFFICIAL DOCUMENTATION

- **Executive Order**
- **Interagency Agreement**
- **Confidentiality Form**

APPENDIX B. CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

STATE OF NEW HAMPSHIRE
CONCORD, NEW HAMPSHIRE 03301

Executive Order Number _____

an order supporting the continuation of a
New Hampshire Child Fatality Review Committee

WHEREAS, as Governor, I have expressed special interest in improving services to children who are victims of abuse and neglect; and

WHEREAS, the U.S. Advisory Board on Child Abuse and Neglect has recommended that efforts be made to address the issue of child fatalities; and

WHEREAS, the formation of a standing committee composed of representatives of state agencies and relevant professional fields of practice will establish a useful repository of knowledge regarding child deaths; and

WHEREAS, in order to assure that New Hampshire can provide a continuing response to child fatality cases, the New Hampshire Child Fatality Review Committee must receive access to all existing records on each questionable or unexplained child death. This would include social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family; and

WHEREAS, the comprehensive review of such child fatality cases by a New Hampshire Child Fatality Review Committee will result in the identification of preventable deaths and recommendations for intervention strategies; and

WHEREAS, the New Hampshire Child Fatality Review Committee represents an additional aspect of our effort to provide comprehensive services for children throughout the State of New Hampshire.

NOW, THEREFORE, I, Jeanne Shaheen, Governor of the State of New Hampshire, do hereby establish a multi-disciplinary child fatality review committee. The objectives of this committee shall be:

1. To enable all interested parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.
2. To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.

3. To evaluate the service system responses to children and families who are considered to be high risk, and to offer recommendations for any improvements in those responses.
4. To identify high risk groups for further consideration by executive, legislative or judicial branch programs.
5. To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
6. To describe trends and patterns of child deaths in New Hampshire.

Given under my hand and seal at the Executive
Chambers in Concord, this _____ day of
August in the year of our Lord, one thousand
nine hundred and ninety-nine.

Governor of New Hampshire

INTERAGENCY AGREEMENT

THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

This cooperative agreement is made between the New Hampshire Department of Justice, the New Hampshire Department of Health and Human Services and the New Hampshire Department of Safety.

WHEREAS, the parties hereto as vested with the authority to promote and protect the public health and to provide services which improve the well-being of children and families.

WHEREAS, under RSA 125:9 II, the Department of Health and Human Services - Division for Public Health has the statutory authority to: “Make investigations and inquiries concerning the causes of epidemics and other diseases; the sources of morbidity and mortality; and the effects of localities, employments, conditions, circumstances, and the environment on the public health.”

WHEREAS, under RSA 169-C, the Department of Health and Human Services - Division for Children, Youth and Families has the responsibility to protect the well-being of children and their families.

WHEREAS, the objectives of the New Hampshire Child Fatality Review committee are agreed to be:

- 1) To describe trends and patterns of child deaths in New Hampshire.
- 2) To identify and investigate the prevalence of a number of risks and potential risk factors in the population of deceased children.
- 3) To evaluate the service and system responses to children and families who are considered to be high risk, and to offer recommendations for improvement in those responses.
- 4) To characterize high risk groups in terms that are compatible with the development of public policy.
- 5) To improve the sources of data collection by developing protocols for autopsies, death investigations and complete recording of cause of death on the death certificates.
- 6) To enable the parties to more effectively facilitate the prevention, investigation and prosecution of child fatalities.

WHEREAS, all parties agree that the membership of the New Hampshire Child Fatality Review Committee needs to be comprised of the following disciplines: law enforcement, judiciary, medical, mental health, public health, child protection services, with specific membership from designated agencies to include, but not to be limited to: the Office of the Chief Medical Examiner, the New Hampshire Pediatric Society and the New Hampshire SIDS Program.

WHEREAS, the parties agree that meetings of the New Hampshire Child Fatality Review committee will be held no fewer than six (6) times per year to conduct reviews of child fatalities.

NOW, THEREFORE, it is hereby agreed that the New Hampshire Child Fatality Review Committee convenes under the official auspices of the New Hampshire Department of Justice. All members of the New Hampshire Child Fatality Review Committee will sign a confidentiality statement that prohibits any unauthorized dissemination of information beyond the purpose of the review process. The New Hampshire Child Fatality Review Committee shall not create new files with specific case identifying information. Non-identified, aggregate data will be collected by the Committee. Case identification will only be utilized in the review process in order to enlist interagency cooperation. No material may be used for reasons other than that which it was intended. It is further understood that there may be individual cases reviewed by the Committee which will require that a particular agency be asked to take the lead in addressing a systemic or quality of care issue based on that agency's clear connection with the issue at hand.

Attorney General

Date

Commissioner, Health and Human Services

Date

Commissioner, Department of Safety

Date

CONFIDENTIALITY AGREEMENT FOR
THE NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE

The purpose of the New Hampshire Child Fatality Review Committee is to conduct a full examination of unresolved or preventable child death incidents. In order to assure a coordinated response that fully addresses all systemic concerns surrounding child fatality cases, the New Hampshire Child Fatality Review Committee must have access to all existing records on each child death. This includes social service reports, court documents, police records, autopsy reports, mental health records, hospital or medical related data and any other information that may have a bearing on the involved child and family.

With this purpose in mind, I the undersigned, as a representative of:

agree that all information secured in this review will remain confidential and not be used for reasons other than that which was intended. No material will be taken from the meeting with case identifying information.

Print Name

Authorized Signature

Witness

Date

NEW HAMPSHIRE CHILD FATALITY REVIEW COMMITTEE STATUTORY AUTHORITY

As a condition for receiving funds from the New Hampshire Department of Justice through the Children's Justice Act Grant, administered by United States Department of Health and Human Services, the State of New Hampshire is required to establish a citizen/professional review panel to "evaluate the extent to which the agencies are effectively discharging their child protection responsibilities." The New Hampshire Child Fatality Review Committee meets the criteria for this review process. 42 U.S.C. 5106a(c)(A). (CAPTA, Child Abuse Prevention & Treatment Act).

The membership is composed of "volunteer members who are broadly representative of the community in which such panel is established, including members who have expertise in the prevention and treatment of child abuse or neglect." 42 U.S.C. 5106a(c)(A)(B).

The 1996 CAPTA amendments require:

The amendments continue the requirement that, to receive funding, a state must have in effect methods to preserve confidentiality of records "in order to protect the rights of the child and of the child's parents or guardians." The persons and entities to which reports and records can be released include:

- (II) Federal, State, or local government entities, or any agent of such entities, having a need for such information in order to carry out its responsibilities under law to protect children from abuse and neglect;
- (III) child abuse citizen review panels;
- (IV) child fatality review panels;
- (VI) other entities or classes of individuals statutorily authorized by the State to receive such information pursuant to a legitimate State purpose. (42 USC 5106a(b)(2)(A)(v))

Confidentiality provisions prohibit the panel's disclosure "to any person or government official any identifying information about any specific child protection case with respect to which the panel is provided information" or making any other information public unless authorized by state statutes. The amendments further provide that the state shall establish civil penalties for violation of the confidentiality provisions, 42 USC 5106a(c)(4)(B).